indicated that the lesion was essentially one-sided, that it was most probably extradural, and rather diffuse.

A CASE FOR DIAGNOSIS; POSSIBLY SYRINGOMYELIA.

By Dr. Edwin G. Zabriskie.

The patient was a boy of nineteen, a native of Silesia, and a baker by occupation. No satisfactory family history was obtainable, but he had apparently enjoyed good health up to the time of his present illness. He used tobacco and beer moderately. About a year ago he fell on the sidewalk, striking his left elbow and causing a fracture of the olecranon. Shortly afterwards, his left hand became emaciated and weak, beginning in the middle finger and extending across the hand to the thumb, the condition taking about two months to develop. Since then the hand had been growing progressively weaker, and a month ago the right hand became similarly affected. The electrical reactions showed complete loss of response to both galvanic and faradic stimulation. The reflexes were present in the biceps and triceps, but the wrist reflex could not be elicited unless the muscle was struck directly. The knee jerks were unequal, the left being greater than the right. There was a well-defined Babinski. The patient had a pronounced scoliosis. There was decided analgesia and thermo-anesthesia in a well-defined area about the elbows, and the temperature sense over the rest of the body was also impaired. There was no vesical nor rectal disturbance. The speaker said he was inclined to regard the case as one of syringomyelia.

Dr. L. Pierce Clark said he thought the case was undoubtedly one of syringomyelia. He thought the speaker was trying to involve the peripheral trauma as a cause of the syringomyelia, which he considered unlikely to be the case, although not a few neurologists held that view.

Dr. Fraenkel said that some years ago he saw a patient with marked chronic degenerative disease of the cord. The symptoms were reported to have come on about three weeks after an accident. The speaker was at that time already able to make a diagnosis of amyotrophic lateral sclerosis. Subsequently, the case came to court, the patient claiming that his disease was the result of the injury he had sustained. Dr. Fraenkel said that he did not coincide with that view, and testified to that effect, but other physicians testified to the contrary, and the jury took their view of the case.

Dr. Noyes said that last spring he showed a case of amyotrophic lateral sclerosis in which the symptoms developed two months after the patient had sustained an electric shock from a third rail, which severely burned his hand. There was a possibility, however, that the symptoms might have been the result of lead poisoning, though no symptoms of lead poisoning were obtained, and the patient gave an indefinite history of weakness of the muscles supplied by the posterior interosseous nerve prior to the accident. There was a scar of an old stab wound inflicted many years before directly over the nerve, and there had been no increase of the paralysis before the electric shock. The symptoms had grown progressively worse quite rapidly, the muscles of the legs and neck now being affected, together with some symptoms of bulbar paralysis. Dr. Noyes said he was still inclined to believe that the electric shock was the cause of the symptoms in this case.

Dr. Zabriskie, in closing, said that while he was inclined to look upon the case as one of syringomyelia, the relation of the symptoms to the accident was very significant. He had found several cases on record where a very definite connection was traced between an injury and the onset of syringomyelia.

REMARKS ON MYOCLONUS EPILEPSY, WITH REPORT OF A CASE.

By Dr. L. Pierce. Clark.

The case reported was of the family type, and was briefly as follows: The patient was a woman, fifty-two years old, single, who was admitted to the Craig Colony for Epileptics on Sept. 30, 1904. Her paternal grandmother had always suffered from headaches. A paternal uncle had three children, one boy and two girls, all of whom suffered from myoclonus-epilepsy similar to that of this patient. The disease was known in the family as St. Vitus' dance and fits. Whether the epilepsy or myoclonus developed first in the cousins was not certain. The eldest of the myoclonus-epileptic cousins (female) married and had one child, who lived to an adult age and showed no signs of the disease or other nervous affection. The mother died of an unknown disease at fifty years of age. The two male myoclonus-epileptic cousins died of unknown diseases at the ages of twenty-five and thirty, respectively. A maternal granduncle was insane and had several children who were insane; one grandson (second cousin to the patient) died of paresis. Several maternal relatives had tuberculosis. The father and mother of our patient were first cousins. Both suffered from chronic rheumatism. The father was still living and was a fairly healthy man of seventy-five years.

The patient was a strong child. She had an ordinary attack of typhoid fever at ten years of age. She began school at five years of age and made the average progress of her grades until thirteen years of age, when she had a typical grand mal epileptic fit at night, without obvious cause. The myoclonus, which either immediately preceded or followed the fit, began in the arms first. Although it was more or less constant after its inception, its paroxysmal intensity at stated periods was certain. On the bad days, the myoclonus often interfered with her piano practice. It was interesting to note that the patient saw her myoclonic cousins a few months prior to the onset of her own disease, and she was much affected by the sight. The fits were rather severe in her fourteenth year, and on one occasion she had seven severe fits in one night. From fifteen to forty-two years of age the attacks were less frequent, averaging one a month. She was now having eight attacks a year; four grand mal and four petit mal, equally divided between day and night attacks. An aura of a cramp-like sensation in the right wrist was invariably present formerly, but it was now absent. For several years after the onset of her association disease she had increasing vertigo and myoclonic movements for two or three weeks before the genuine fits occurred, after which she was perfectly free from myoclonus for two or three days. The myoclonus never interfered with nor did it occur during sleep. Bromide and chloral, particularly the latter, improved her condition considerably during the thirteen years of their use, from the onset of the disease. She was now a Christian Scientist, and had taken no medicine for several years. Coffee had some quieting effect on the myoclonic movements. The patient had nocturnal enuresis until she was thirty-one years of age; this stopped with-